Skilled Nursing Facility MMP Quick Reference Document

Topic	Amerigroup	Cigna – Health Spring	Molina	Superior	United
MCO Website	https://www.myamerigroup.com/txmmp	www.careplantx.com	www.molinahealthcare.com	http://www.superiorhealthplan.com/	**http://www.uhccommunityplan.com/tx.html**
MCO Provider Website	https://providers.amerigroup.com/TX	http://www.cigna.com/medicare/healthcare-professionals/tx-mmp	http://www.molinahealthcare.com/providers/tx/medicaid/pages/home.aspx	http://www.superiorhealthplan.com/for-providers/	**www.UnitedHealthcareOnline.com**
Claim filing deadline for Medicare (Part A or Part B)	Initial Claim: 95 calendar days from the date of service Reconsideration or Disputed Claim: 120 calendar days from the date of disposition to appeal	Claim: 95 days from the date of Initial service Reconsideration, or Disputed Claim: 120 calendar days from the date of disposition to appeal	Initial claim: 365 days from date of service Adjusted/Corrected Reconsiderations, or Disputed Claim: 120 days from last timely processed claim	Initial Claim: 95 days from date of service. Adjusted/Corrected, Reconsideration, or Disputed Claim: 120 calendar days from last timely processed claim	Initial Claim: 95 days from date of service. Adjusted/Corrected, Reconsideration, or Disputed Claim: 120 calendar days from last timely processed claim
Claims Adjudication Timeframe Medicare(Part A or Part B)	NF – 10 calendar days from the clean claim received date 30 calendar days from the clean claim received date	30 Days from claim received date	30 days from claims received date	30 Days from claim received date	NF – 10 calendar days from the clean claim received date 30 Days from claim received date

Claims Filing deadline Nursing Facility Claims (SNF co-insurance and Non-SNF)	Initial Claim: 365 calendar days from date of service. Adjudication of a Deficient Claim must be received from the provider within 30 days from the date of the Received Date of Claim. The MCO must adjudicate Deficient-Pended or Deficient-Denied Claims for which additional information is request within 30 days from the date of receipt of the requested information.	Initial Claim: 365 days from date of service. Reconsideration, or Disputed Claim: 120 calendar days from last timely processed claim	Initial Claim: 365 days from date of service. Adjusted/Corrected Reconsideration, or Disputed Claim: 120 calendar days from last timely processed claim.	Initial Claim: 365 days from date of service. Adjusted/Corrected, Reconsideration, or Disputed Claim: 120 calendar days from last timely processed claim	Initial Claim: 365 days from date of service. Adjudication of a Deficient Claim must be received from the provider within 30 days from the date of the Received Date of Claim. The MCO must adjudicate Deficient-Pended or Deficient-Denied Claims for which additional information is requested within 30 days from the date of receipt of the requested information.
Medicare and Medicaid	Provider can submit one claim	Provider only needs to submit one claim	Provider only needs to submit one claim	Provider must submit separate claims	UnitedHealthcare is modifying its payment

claims filed on one or two separate claims?	• SNF claims must use standard Medicare revenue codes • Medicaid coinsurance claims should bill with Revenue Code 101 • Non-skilled Medicaid NF claims should be billed with Revenue Code 100 • Medicare Part B Services must use standard Medicare codes	• SNF claims must use standard Medicare revenue codes • Medicaid coinsurance claims should bill with Revenue Code 101 • Non-skilled Medicaid NF claims should be billed with Revenue Code 100 on a separate claim	• Molina will create the secondary co-insurance claim and pay both claims with one payment • SNF claims must use standard Medicare revenue codes • Medicaid co-insurance claims should bill with Revenue Code 101 • Non Skilled Medicaid NF claims should continue to be billed with Revenue Code 100 • Medicare Part B services must be submitted on a separate claim	• SNF claims must use standard Medicare revenue codes • Medicaid coinsurance claims should bill with Revenue Code 101. • Non-skilled Medicaid NF claims should be billed with Revenue Code 100 • Medicare Part B Services must use standard Medicare codes	methodology: (Current State) Under current payment methodology, providers can bill with the 190 series for the revenue code for skilled services. Providers will continue to bill NF unit rate claims with the 0100 revenue code and coinsurance claims with 0101. ~~u~~ Effective 1/1/16 (or sooner) Provider will need to submit separate claims for Skilled and Medicaid room and board claims. Coinsurance claims can be submitted on the same claim as Medicaid room and board claims. Skilled must use

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			using standard Medicare codes		standard Medicare revenue codes • Medicaid coinsurance claims should bill with Revenue Code 101 • Non-skilled Medicaid NF claims should be billed with Revenue Code 100 • Medicare Part B Services must use standard Medicare codes and must be on a separate claim.
Applied Income – Medicare co-insurance	Applied Income should be collected during co-insurance period. **Do not deduct the AI for the claims**. The	Applied Income should be collected during co-insurance period. **Do not deduct the AI for the claims**. Co-	Applied Income should be collected during co-insurance period. **Do not deduct the AI for the claims**. Co-	Applied Income should be collected during co-insurance period. **Do not deduct the AI for the claims**. Co-insurance	Applied Income should be collected during co-insurance period**. *Do not deduct the AI for***

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	Applied Income amount will be automatically reduced on the Medicaid portion of the claim by the MCO -.	insurance payment is reduced by the Member's AI.	insurance payment is reduced by the Member's AI.	payment is reduced by the Member's AI.	***the claims.*** The Applied Income amount will automatically be prorated/reduced on the portion of the co-insurance claim..
How to submit claims	**Electronic Clearinghouses:** • Emdeon (Payer ID# 27514) • Availity (Payer ID# 26375) • Capario (Payer ID# 28804) **Electronic Data Interchange (EDI):** 1-800-590-5745 **Amerigroup's Provider Portal**: https://providers.amerigroup.com/TX	**Electronic Clearinghouse** Payer ID 52192 • Emdeon • PayerPath • Availity **Via secure online provider portal** https://STARPLUS.HSConnectOnline.com/login **Mail** Cigna-HealthSpring P.O. Box 981709 – CarePlan El Paso, TX 79998-1709	**Electronic Clearinghouse:** Payer ID 20554 **Molina's Provider Portal:** www.molinahealthcare.com Batch Billing may be done via EDI link on the Molina Provider Portal **State website:** www.tmhp.com	**Electronic Clearinghouse:** Payer ID 68069 (Field CLM05-3=7 and Ref*8 = Original Claim Number) **Electronic Data Interchange (EDI):** 1-800-225-2573 ext 25525 **Superior Provider Portal:** http://www.superiorhealthplan.com/for-providers/ **State Website** www.tmhp.com	**Electronic Clearinghouses:** Payer ID 87726 • Office Ally (preferred UHC Clearinghouse) • Any Clearinghouse of provider's choice **Electronic Data Interchange (EDI) Help Desk:** 1-800-210-8315 **United Provider Portal:**

	State Website www.tmhp.com **Mail:** Amerigroup Star+Plus MMP Claims Dept. P.O. Box 61010 Virginia Beach, VA 23466-1010	**State website** www.tmhp.com		**Mail:** Superior STAR+PLUS MMP Claims Dept. P.O. BOX 3060 Farmington, MO 36340-3822	www.UnitedHealthcareOnline.com **State Website** www.tmhp.com
MCO Internet Web Portals	https://providers.amerigroup.com/TX Providers must register a User ID & Password online when accessing the Provider Portal. Provider Portal allows 24-hour access and is an interactive site where Providers are allowed to: • Verify member eligibility • File and check the	https://STARPLUS.HSConnectOnline.com/login Cigna-HealthSpring's secure Provider Portal is available to participating providers only. Providers must have a User ID & Password to access the Provider Portal. New Providers must register a User ID & Password online when accessing the Provider Portal.	https://provider.molinahealthcare.com/ Nursing Facility providers may register for access to the Molina E-Portal for self service. The E-Portal is a secure website that allows our providers to perform many self-service functions 24 hours a day, 7 days a week: • Check member eligibility • Submit claims • Claims status	www.superiorhealthplan.com/for-providers/ Providers must register a User ID & Password online when accessing the Provider Portal. Provider Portal allows 24-hour access and is an interactive site where Providers are allowed to: • Verify member eligibility • File and check the status of claims	**www.UnitedHealthcareOnline.com** Providers must register a User ID & Password online when accessing the Provider Portal. Provider Portal allows 24-hour access and is an interactive site where Providers are allowed to: • Verify member eligibility and benefits

	status of medical claims • Request authorizations and retrieve status • Submit a Pharmacy Prior Authorization Request • Provider Manual • Precertification Lookup Tool • Electronic remittance advice and electronic funds transfer information • Various administrative forms	The Provider Portal allows 24-hour access and is an interactive site where participating Providers are allowed to: • Verify member eligibility and PCP • Check individual claim status or by batch • Submit individual CMS 1500 claims • Submit batch claims for UB04 and CMS 1500 claims • Request authorizations and check status • Verify member's Service Coordinator HSConnect Technical Support 1-866-952-7596	inquiry • Run claims reports/ history. • Correct a claims in the system • Submit/follow request for prior authorization • Access NF specific provider manual, training materials, etc.	• Request authorizations and retrieve status • Submit a Pharmacy Prior Authorization Request • Provider Manual • Precertification Lookup Tool • Electronic remittance advice and electronic funds transfer information • Various administrative forms	• File and check the status of medical claims and payments • Request authorizations and retrieve status • Submit a Pharmacy Prior Authorization Request • Review Provider Manual • Administrative Guides • Electronic remittance advice and electronic funds transfer information • Various Clinician Resources

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Authorization Request form	Texas Standard Prior Authorization Request Form may be utilized by the facilities to request prior authorization for health care services. www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf	Texas Standard Prior Authorization Request Form for Health Care Services can be utilized for prior authorization of a health care service. www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf	Texas Standard Prior Authorization Request Form can be utilized by the facilities to request prior authorization for health care services. www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf The Molina E-Portal is the preferred methodology to request a prior authorization. Prior authorization may also be faxed using the forms:http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/Prior-Authorization-Guide-	Texas Standard Prior Authorization Request Form can be utilized by the facilities to request prior authorization for health care services. www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf Prior authorization may be faxed using the forms:http://www.superiorhealthplan.com/for-providers/starplus-mmp/	Texas Standard Prior Authorization Request Form can be utilized by the facilities to request prior authorization for health care services. www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf Forms can be faxed to 866-785-1649 or complete authorization requests at unidedheatlhcareonline.com

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Prior Authorization Criteria for Part A/SNF admissions	Admissions are reviewed for medical necessity using McKessson InterQual ® National Standard Criteria. • Determination within 3 business days; 1 business day for expedited (urgent) decisions Clinical information to substantiate medical necessity criteria should be submitted with to support request for services. This should include physician history and physical therapy notes showing need	Admissions are reviewed for medical necessity using McKessson InterQual ® national standard criteria. • Determination within 3 business days; 1 business day for expedited (urgent) decisions • Out of network – determination within 5 business days Clinical information supporting the need for the service to be rendered should be submitted. Generally, information needed includes, but not limited to H&P, therapy notes showing need for services/prior level	Admissions are reviewed for medical necessity using McKessson InterQual ® national standard criteria. Decision within 3 business days Expedited (urgent) decision within 1 business day. Clinical documentation should be submitted with to support request for services. Generally information needed is: H&P, therapy notes showing need for services/prior level of function, Medication list, MD order, nursing and	Admissions are reviewed for medical necessity using McKessson InterQual ® criteria. Decision within 3 business days Expedited (urgent) decision within 1 business day. Clinical documentation should be submitted with to support request for services. Generally information needed is H&P, therapy notes showing need for services/prior level of function, Medication list, MD order, nursing and physician progress notes, labs/x-ray information. We initially authorize	If member participates in the Complex Population Management program, the Nurse Practitioner will assist to initiate skilled services immediately. If a member does not participate in this program, the process outlined below is followed: Admissions are reviewed for medical necessity using Milliman Care Guidelines. 24 Hour admit notification required for skilled

	for services and prior level of function, physician orders, tests, treatments, interventions performed and results, outcomes and progress should be faxed to 1-844-206-3445.	of function, Medication list, physician order, nursing and physician progress notes, labs/x-ray information.	physician progress notes, labs/x-ray information. We initially authorize 7 days and review every 6 days after the initial approval.	7 days and review every 6 days after the initial approval	admissions • Online via Unintedhelathcareonline.com • Phone via 877-285-9093 option 1 Admit notification must be received within 24 hours of the admission/change of status to a skilled stay for in-house patients or by 5 pm local time next business day if on a weekend or federal holiday. Penalties: • Admission Notification received after it was due but not

					more than 72 hours after admission causes a 100% reduction of the daily contracted rate for the days preceding the notification. • Admission Notification received after it was due and more than 72 hours after admission or no notification received at all will result in 100% reduction of the

					contracted rate for the entire skilled stay. Case Managers will reach out to the facility for clinical documentation to determine continued stay. Generally information needed is H&P, therapy notes showing need for services/prior level of function, Medication list, MD order, nursing and physician progress notes, labs/x-ray information. Authorization

					timelines will be given based upon clinical need. Any appeals to the above will follow normal appeal guidelines.
Medical Necessity Appeals	**Mail:** Amerigroup STAR+Plus MMP Complaints, Appeals & Grievance Department P.O. Box 61116 Virginia Beach, VA 23466-1116 **Fax:** 1-855-856-1724 Medical Appeals can be initiated by the member or the provider, on behalf of the member with the member's consent, and must be submitted within 30	**Fax** 1-877-809-0783 **Secure online provider portal** https://STARPLUS.HSConnectOnline.com/login **Mail** Cigna-HealthSpring Care-Plan Appeals & Complaints Department PO Box 211088 Bedford, TX 76095	Molina Healthcare of Texas Attn: Provider Complaints & Appeals P.O. Box 165089 Irving, TX 75016 Fax to (877) 319-6852	Superior HealthPlan STAR+PLUS MMP Attn: Appeals/Denials Coordinator 2100 South IH-35, Ste. 200 Austin, Texas 78704 Phone: 1-877-398-9461 Medical Appeals can be initiated by the member or the provider, on behalf of the member with the member's consent, and must be submitted within 30 calendar days from the receipt of an adverse	Standard appeals – Appeals and Grievances UnitedHealthcare Community Plan P. O. Box 31364 Salt Lake City, UT 84131-0364 or Phone: 1-800-256-6533 (TTY 7-1-1). Expedited appeals-Phone: 1-800-256-6533 (TTY 7-1-1).

	calendar days from the receipt of an adverse determination.			determination.	
Prior Authorization department contact Information	Phone: 1-855-878-1785 Fax: 1-888-235-8468 (Inpatient) Fax: 1-888-235-8468 (Outpatient) Fax: 1-844-206-3450 (LTSS) Fax: 1-844-206-3445 (Nursing Facility)	1-877-725-2688, follow prompts for "providers" Fax: 1-877-809-0786 (Inpatient) Fax: 1-877-809-0787 (Outpatient) Fax: 1-877-809-0788 (LTSS)	**Phone #---(866) 449-6849** Fax to (866-420-3639	Phone: 1-800-218-7508 Inpatient Fax: 1-877-259-6960 Outpatient Fax: 1-877-808-9368	1-877-285-9093 Fax: 866-785-1649
Service Coordination Hotline	1-855-878-1785(TTY:711)	1-877-725-2688(TTY:711)	Phone : 866-409-0039 (TTY:711)	1-855-772-7075 (TTY:711)	1-800-349-0550(TTY:711)
Member Services Hotline	1-855-878-1784 (TTY:711)	1-877-653-0327(TTY:711)	1-866-449-6849 (TTY:711)	1-866-896-1844(TTY:711)	1-800-256-6533 (TTY:711)

Provider Services Hotline	Provider Service Line: 1-855-878-1785 Nursing Facility Service Line: 1-866-696-0710 Option 5	1-877-653-0331	1-866-449-6849 NFProviderServices@molinahealthcare.com	1-877-391-5921	1-888-887-9003
Claim Appeals	**Mail A Payment Appeal To:** Amerigroup STAR+Plus MMP Provider Payment Appeals PO Box 61116 Virginia Beach, VA 23466-1116 **Amerigroup's Provider Portal:** https://providers.amerigroup.com/TX A provider has 120 calendar days from of the initial Amerigroup STAR+PLUS MMP decision date listed	**Fax** 1-877-809-0783 **Secure online provider portal** https://STARPLUS.HSConnectOnline.com/login **Mail** Cigna-HealthSpring Care-Plan Appeals & Complaints Department PO Box 211088 Bedford, TX 76095	Requests for claim reconsideration should be mailed to: 5605 N MacArthur Blvd., Suite 400 Irving, TX 75038 Attn: PIRR (Provider Inquiry Research & Resolution) Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim or it will result in claim denial and mailed to the address	Adjusted or Corrected Claims: *(Provider is CHANGING the original claim)* Provider is able to submit claim through portal, EDI or paper Claim Dispute: *(Provider disagrees with the outcome or Request for Reconsideration)* Superior STAR+PLUS MMP Attn: Claims - Reconsideration OR Dispute P.O. Box 4000 Farmington, MO 63640-4000	Reconsideration requests Submit a Reconsideration form found at UHCCommunityPlan.com or submit directly via UnitedHealthcare Online.com to have claims reviewed; Claims appeals Complete Appeal Request Form (located at UHCCommunityplan.com) Mail the form to: Appeals and Grievances

	on the Explanation of Payment (EOP) to file a payment appeal.		referenced in section A.		UnitedHealthcare Community Plan P. O. Box 31364 Salt Lake City, UT 84131-0364
Benefit Period	Skilled benefit period • Medicare allows for 100 days • 1 benefit period per year 60 day Spell of Illness break is required				Skilled Nursing Stay benefit period will follow the same guidelines as standard Medicare Skilled benefit. • Up to 100 days per period based upon clinical need • 60 day break of spell of illness in order to reset days Unlimited benefit periods per year following the above guidelines
Facilities outside of	Member benefits would remain				

demo areas	unchanged unless member permanently moves out of a participating MMP Countydemo area.				
Out of Network physicians and ancillary providers	Continuity of Care • 90 day for non-nursing facility members 180 days nursing facility members				
Provider Manual Link					http://www.uhccommunityplan.com/health-professionals/tx/provider-training.html
Admission Notification Process					UHC has the skilled in place option which requires the 24 hour admit notification as outline in the Prior Auth section above.

Authorization Increments					Based upon clinical need and decided by the Clinical Case Manager.
Process/contacts for residents admitted in facilities outside the demo counties					The same process will apply outside of the demo counties for admission notification. Provider must contact Maximus if the member plans on staying in the area that is outside of the demo area in order to change to a provider that services that SDA.
Process/contacts for physicians and ancillary providers that are not contracted with the MMP					The same process will apply outside of the demo counties for admission notification. Provider must contact Maximus if the member plans on staying in

					the area that is outside of the demo area in order to change to a provider that services that SDA.
How do I get assistance with Pharmacy Services?	Express Scripts, Inc. (ESI) Pharmacy Prior Authorization Phone Line: 1-855-878-1785 Pharmacy Prior Authorization Fax Line: Fax: 1-800-359-5781 View a copy of the formulary at: https://providers.amerigroup.com/TX BIN# 003858 PCN# MD	Catamaran www.catamaranrx.com Pharmacy Prior Authorization Phone Line: 1-866-653-0327 Pharmacy Prior Authorization Fax Line: 1-866-845-7267 View the MMP formulary at http://www.cigna.com/sites/careplantx/medicare-medicaid-plan/drug-list.html BIN# 017010, PCN CIHSCARE	Pharmacy Help Desk: 1-877-874-3317 Pharmacy Prior Authorization: 1-855-32-4080; Option #1, Option#2 Fax: 1-888-487-9251 BIN# 004336, PCN ADV	US Script www.usscript.com Pharmacy Help Desk: 1-877-935-8021 Prior Auth Hotline - Phone: 1-866-399-0928 Fax: 1-877-941-0480 BIN# 012353, PCN 06244500	Physician Prescription Prior Authorization: Electronic submission 24/7 visit www.OptumRx.com > Health Care Professionals Fax: 800-527-0531 (non- urgent) Phone: 800-711-4555 (urgent) Pharmacists: 877-889-6510 Pharmacy Mail Order: 877-889-5802 Drug Formulary: http://www.uhccommunityplan.com/tx/medicaid/Connected.html BIN: 610997, PCN: 8500
